STATE OF VERMONT AGENCY OF HUMAN SERVICES

Recommendations
For the Future of Services
Provided at the Vermont State Hospital

Strengthening the Continuum of Care For Vermonters with Mental Illness

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Recommendations for the Future of Services Provided at the Vermont State Hospital; Strengthening the Continuum of Care for Vermonters with Mental Illness

Pursuant to Sec 141(a) and (b) of the Appropriations Act for 2005, I am pleased to offer a plan for the future delivery of in-patient services that are currently provided at the Vermont State Hospital (VSH). In addition, I am pleased to offer recommendations to strengthen the entire service system for Vermonters with mental illness and substance abuse disorders, and to ensure that the recommendations of the corrections mental health service plan are coordinated with and complementary to my recommendations for the continuum of care. Also included, as directed in the statute, are timelines and operating cost estimates.

Vermont law directs that it be our policy "to work towards a mental health system that does not require coercion or the use of involuntary medication." In light of this policy, at every point in our planning process, we should be seeking ways to reinforce a system that maximizes reasonable choices of voluntary services and avoids or minimizes involuntary treatment. While acknowledging that court ordered or involuntary care is sometimes required, we ask that these recommendations be read with this policy in mind.

As this document was in its final stages, news came of the second decertification of the Vermont State Hospital (VSH). Governor Douglas directed immediate remedial actions, and directed that the planned downsizing and closing of the hospital be accelerated in a responsible way. This document is not designed to respond to the Governor's directive. That response will be an action plan, which is being developed and which will be delivered on Tuesday, February 8, 2005. The action plan, to the greatest extent possible, will be consistent with the longer-term vision offered in this report. The timelines in this document were not changed following the news of decertification and should be read with the understanding that they all are under active reconsideration as the result of the Governor's directive.

A Unique Opportunity

Vermont's mental health system has many strengths of which we can be proud. The system also has significant challenges. From these challenges arises a unique opportunity for major system improvement.

On the positive side, Vermont's system compares favorably among all states with regard to many best-practice standards and outcome measures. Vermont has moved definitively and successfully in deinstitutionalizing care and improving outcomes for citizens with mental illness. While we once served 1,350 citizens in the Waterbury hospital facility, we now treat fewer than 50 Vermonters, on average, in that setting. Instead, we assist 3,200 individuals with severe mental illness through the community mental health based

¹ 18 V.S.A. § 7629(c).

CRT² program, and we have a network of five designated hospitals³ to provide in-patient, involuntary care closer to home.

On the negative side, we continue to struggle with long-standing, systemic problems at VSH. Under exceedingly difficult circumstances, staff and management achieved recertification last year, only to lose it again this month. Overall, a convergence of events and forces has clearly shown that aspects of Vermont's mental health system of care need serious improvement. These events and forces include:

- Suicides at VSH and the subsequent decertification,
- More recent safety and security breaches that resulted in a second decertification,
- Suicides and other deaths in the prison system,
- A decision⁴ by the federal government to terminate funding for "institutes of mental disease" (IMDs) including VSH,
- An investigation by the U.S. Department of Justice with respect to civil rights issues at VSH,
- Wide recognition that the VSH premises are antiquated and cannot be considered a suitable therapeutic setting for recovery from mental illness, and
- An increasing number of patients with co-occurring substance use disorders.

It is also clear that services are not well coordinated across the continuum of mental health care, from primary care providers to the community partners, to the designated hospitals, to the VSH and prisons; that many services, especially in the adult out-patient and substance abuse categories, are bottle-necked at the community level; that opportunities for effective early intervention are being missed; and that many Vermonters in need are not receiving services. Further, it is clear that the community mental health system has faced increasing demands for service, with limited funds allocated for cost of living and inflationary pressures.

This plan, fully implemented, would transform in-patient and rehabilitation services for the most severely ill. It would improve coordination of services and increase capacity for all adults with mental health problems. The result would be a continuum in which all of the elements are coordinated; in which prevention, early intervention and alternatives to hospitalization are pursued aggressively; in which peer supports are expanded and fully respected as essential to recovery; in which the individual is actively engaged in the

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² Community Rehabilitation and Treatment programs offer a full range of mental-health supports and services for adults with diagnoses of major mental illnesses such as schizophrenia, bipolar disorder, major depression, and serious disorder of thought or mood. In addition to diagnosis, criteria for enrollment in a CRT program involve long-term disability (as evidenced by social isolation or poor social functioning, a poor work history, or Supplemental Security Income) and a recent history of intensive and ongoing mental-health treatment (multiple psychiatric hospitalizations, for example, or six consecutive months of outpatient treatment).

³ With respect to mental health, a designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly by the Commissioner of Developmental and Mental Health Services) to provide treatment to individuals involuntarily committed to the commissioner's care and custody.

⁴ This decision applies to all IMDs and was not prompted by any problems at VSH.

development of his or her treatment plan; and in which outcomes are measured and continuous improvement is a key goal.

Included in the plan are recommendations to establish or strengthen:

- In-patient intensive and acute-care hospital services,
- Sub-acute therapeutic residential services,
- Secure residential services,
- Community based, hospital diversion services,
- Peer support services,
- Housing support services,
- Service coordination and delivery for incarcerated offenders with mental illnesses,
- Adult out-patient services including services for offenders in the community,
- Vermont's capacity and competence in prevention, early detection and early stage management of mental disease and co-occurring substance abuse disorders,
- Integration of primary care, substance abuse and mental health services.

Many Contributors

This plan draws on information and guidance from three concurrent processes conducted in the latter half of 2004: the VSH Futures, Corrections Mental Health Planning and Designated Agency Sustainability processes. The plan, while mine, is heavily informed by the work of many dedicated Vermonters. In particular, I want to thank the:

- 30 members of the VSH Futures Advisory Committee,
- 22 members of the Department of Corrections' Comprehensive Mental Health Services Stakeholders Panel,
- 10 members of the Department of Corrections' Comprehensive Mental Health Services Work Group,
- 26 members of the Designated Agency Sustainability Advisory Committee,
- Leaders and staff of the Department of Health's Division of Mental Health and of the Department of Corrections, for countless hours of research, analysis, discussion and drafting.
- Contributions and learnings from the reorganization of the Agency of Human Services made by countless agency personnel and other Vermonters.

Reports were generated from each of the three concurrent processes. They are incorporated by reference and are available on the web at http://www.ahs.state.vt.us/vshfutures/. Otherwise, go to the Agency web page http://www.ahs.state.vt.us and look under AHS News for the VSH Futures report.

Operating Cost Considerations and Framework

The operating cost estimate for this plan is \$21.8 million, of which Vermont's share would be limited to \$13.7 million. The fundamental premise is that Vermont would not

spend more than we had already planned to spend to operate the current VSH in SFY 2006. The remainder is expected from the federal Medicaid program.⁵ Essentially, this plan is cost-neutral to the general fund, with some savings expected in future years.

Going forward, non-medical costs are assumed to increase at the Consumer Price Index (CPI) rate. Medical cost growth would not exceed 7.5 percent annually, reflecting the long-term trend of medical CPI.

Summary of Recommendations and Estimated Costs

 Replacement of Vermont State Hospital's Direct Services⁶ An in-patient facility of up to 28 beds, including 8 psychiatric intensive care unit (ICU) beds, co-located with, managed and governed by an appropriate general hospital: 4 additional intensive care beds located within another of the designated hospitals: 16 beds total, sub-acute rehabilitation, in one, two or three locations (as costs, workforce and bidder proposals allow), operated by private partners that might include hospitals, designated agencies, other contractors, or a consortium of partners: 6-bed secure residential facility, operated by either the Department of Health or by a contractor: 	\$10,500,000 1,500,000 3,300,000 900,000
 Augmented Community-Based Services 10 diversion beds, ⁷ managed by partners, in two or three underserved locations: Additional peer support programming: Additional recovery housing: Additional adult outpatient service: Additional offender out-patient service: 	1,000,000 200,000 400,000 1,200,000 600,000
 Augmented Prison-Based Services Additional staff and service investments called for in the Corrections Mental Health Plan: 	875,000
Agency of Human Services Initiatives Care management: Expansion of the co-occurring disorders project: Public health / mental health and substance abuse prevention and education strategies, including expansion and integration of the primary care depression collaborative project:	275,000 600,000 200,000
MiscellaneousAncillary legal and transportation services: Total:	250,000 \$21,800,000

⁵ This assumption about federal participation in future programs is not related to decertification at VSH. ⁶ These services and their replacement are discussed in more detail in the Vermont State Hospital Futures

⁷ In addition to 18 existing diversion beds, as noted below.

Discussion of Recommendations, Costs and Timelines

Replacement of Vermont State Hospital's Direct Services

The sizing concept underlying this plan is simple: we currently have 54 beds at the Vermont State Hospital and, going forward, we are assuming the need for approximately that same capacity. Some will argue we need more beds; others that we need fewer. It is our intent, our hope and our goal to reduce the need for involuntary hospitalization. This plan would divert individuals from hospitalization, and it may be that bed capacity in the designated hospitals is currently underutilized. On the other hand, we have no guarantee of the success of hospital diversion and the Vermont population is growing. We anticipate increased usage, especially in intensive care, by offenders who cannot be properly served in prison. Until we can measure our diversion success, the prudent course seems to call for maintaining current capacity.

Under the transition strategies discussed below, we can gain experience with the alternatives to hospitalization before we finally determine the size of the new intensive care / specialized facility and the overall system-wide hospital capacity.

The system components and possibilities discussed here have been reviewed by interested parties through a "Request for Information" process, which was conducted in December 2004. Without commitment, indications of strong interest in performing parts of this work were received from Fletcher Allen Health Care, Rutland Regional Hospital, Springfield Hospital, and Retreat Healthcare, as well as from various designated agencies and other community partners.

1. A 28-bed facility, a comprised of a 20-bed specialized in-patient care unit and an 8-swing-bed intensive care unit (ICU), would be built on or near the premises of an appropriate general hospital. It would be operated and governed under the license of the general hospital in accordance with a contract issued by the Department of Health, requiring best practices for the integration of mental, substance abuse and physical care, and operating within the scope of federal Medicaid policy. Because of its size in relation to the size of the governing hospital, this facility would not constitute an IMD and therefore would qualify for federal Medicaid participation. The hospital partner, ideally, would be operated by an academic medical center with strength in public psychiatry. The new facility would be led and developed as a center of excellence for psychiatric hospitalization. The partner would be selected through an RFP process.

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⁸ Assuming approximately comparable costs and quality, acceptable alternative solutions include reducing this facility to as few as 16 beds, of which eight would still be ICU swing beds. The remaining 12 specialized in-patient and ICU beds would be distributed to other interested hospitals with adequate space and clinical capacity to provide excellent service. The final configuration would be determined through an RFP process.

⁹ The facility would be designed with 8 swing beds, to be used either for intensive care or for specialized in-patient purposes, depending on the need at any given time.

This facility, which may be the only new construction project in the plan, would be built at state expense. Occupancy cost would be factored into the comprehensive financial arrangement with the partner. This facility could:

- Offer a secure and safe setting for the intensive care and stabilization of patients who present an extreme risk of harm to themselves or to others. This could include patients who are admitted both voluntarily and involuntarily, and could include incarcerated offenders with extreme mental illness.
- Address the specialized in-patient needs of individuals potentially suffering from a broad array of mental disorders and whose hospitalizations are expected to exceed 30 days.
- Accommodate court-ordered psychiatric evaluations to determine if an alleged offender is competent to stand trial.

Timeline: Ready for occupancy no later than the end of SFY 2009, and earlier if possible.

2. <u>An additional 4-bed psychiatric intensive care unit (ICU)</u> would be established within one of the current designated hospitals, selected through an RFP process. This second ICU location is intended to improve geographic access for those with the most intensive needs.

Timeline: To open during SFY 2006, based on transition plan assumptions, below.

3. One or more sub-acute (i.e., non-hospital, low-security) rehabilitation facilities totaling 16 beds would be established and operated by one or more community hospitals, designated mental health agencies and / or other community-based, private partners. The partner(s) would be selected through an RFP process.

This facility could:

- Be located in a community setting, with walking access to amenities.
- Offer a safe, therapeutic, residential setting for stays of up to and exceeding 12 months.
- Support residents with severe but stabilized illness to work on their rehabilitation and recovery plans.

Timeline: To open during SFY 2006, based on transition plan assumptions below, and subject to receiving a Certificate of Need, if deemed necessary.

4. A secure, long-term, residential setting would be established for up to 6 individuals. The residents would be psychiatrically stable individuals who do not require ongoing inpatient psychiatric care. They would remain in the custody of the Commissioner of Health, based on court orders. This service

could be provided by a contractor or community partner, selected through an RFP process, or by the Department of Health.

Timeline: To open during SFY 2006, based on transition plan assumptions below.

Augmented Community Based Services

1. <u>Diversion (10 new beds)</u>

Ten new diversion beds are planned to augment 18 existing diversion beds. These are run by designated community mental health agencies and other partners around the state and used for crisis stabilization and hospital step down services.

Under this plan, all diversion beds would be available for and adaptable to at least four types of care, with consideration given to a fifth type:

- Triage and observation care (24 hours): This new voluntary program would provide a brief safe haven for individuals who now would stay in a hospital emergency room pending referral. Individuals would remain in triage and observation until assessed by a professional, then released or moved to another level of care.
- Crisis stabilization care (24-48 hours): This existing voluntary program currently offers care for up to two days, after which individuals are stable enough to be released or are transferred to hospital care. Under this plan, individuals who have not stabilized would transfer to a hospital alternative, defined below, unless hospitalization was clearly indicated
- <u>Hospital alternative care (3-7 days):</u> This new voluntary program would focus on delivering professional care and peer support in a non-hospital setting, located as close to the individual's home community as possible.
- Hospital step down care (24-48 hours): This existing program, which offers both voluntary and court-mandated service, would continue to offer care for individuals transitioning from in-patient to outpatient care. Individuals in step down beds typically begin the program upon release from a hospital and are discharged at the end of their one- or two-day stay.
- The fifth type, <u>care for public inebriates</u>, represents a significant need. The possibility that some of the diversion beds could be swing beds for this purpose is worthy of consideration as we engage in the RFP process.

Timeline: To open during SFY 2006, based on transition plan assumptions, below.

2. Peer Services

There is broad recognition that building peer support capacity and employing blended peer / professional models of care are important in promoting resilience and recovery from mental illness. This plan recommends a grant capacity and the solicitation of proposals from peer support organizations and from peer / professional collaborative groups for building up the evidence-based peer-support resources of our continuum of care. Good programs to replicate, or on which to build, include:

- <u>Safe Haven</u>, a Randolph-based peer / professional supported living collaboration between Vermont Psychiatric Survivors and the Clara Martin Center (operated by a community mental health designated agency);
- Recovery Education Project, an established curriculum taught by peers to assist individuals develop personal coping skills and self-advocacy skills, develop natural networks and crisis plans, etc.;
- Another Way, a Montpelier-based, peer support drop in center;
- Community Links, a peer-mentoring pilot project that uses trained and paid peers to assist individuals who are most at risk for repeat episodes of illness resulting in involuntary treatment;
- <u>Vermont Psychiatric Survivors</u>' outreach and advocacy services.

Timeline: SFY 2006 based on transition plan assumptions, below.

3. Recovery housing

Housing is a key component to mental health recovery and to gaining resilience and independence. The annual investment in housing support proposed here could be used various ways including:

- A model similar to that used by the Department of Corrections for transitional offender housing. The Department of Health could work with community organizations to develop housing units for individuals who have no alternative housing and who are in recovery or who are ready for discharge from a hospital or long-term rehabilitation setting. This housing would be a temporary and transitional. The budget would support rental payments and have a limited allocation for staff support.
- Rent assistance, perhaps on the order of \$300 per month, to make rents more affordable for individuals in recovery.

Timeline: SFY 2006 based on transition plan assumptions below.

4. Adult Out-Patient

This portion of the plan calls for added capacity for the community mental health agencies and / or private providers to provide adult out-patient service. The intent is, through an RFP process, to seek highest-impact, innovative strategies to reach the most people with effective interventions. Examples might include:

- A program focused specifically on the mental health needs of service men and women returning from a war zone, and / or their families during the deployment;
- Replication of the HCRS (Health Care & Rehabilitation Services of Southeastern Vermont) program for cost-effective management of pre-CRT (Community Rehabilitation and Treatment) individuals;
- Collaboration with the Department of Children and Families to intervene with specific TANF (Temporary Assistance for Needy Families) families on issues of depression and substance abuse.
- Integration of mental health care into primary care settings such as federally qualified health centers (FQHCs).

Timeline: SFY 2006 based on transition plan assumptions, below.

5. Offender Out-Patient

This portion of the plan calls for capacity for the community mental health agencies and / or private providers to serve the mental health and substance abuse needs of selected offenders who are returning to the community following incarceration. The intent would be, through an RFP process, to seek highest-impact innovative strategies, with priority given to interventions with a high potential of supporting the offender's long-term success.

Timeline: SFY 2006, based on transition plan assumptions, below.

6. Augmented Prison-Based Services

In reference to the Department of Corrections' Comprehensive Mental Health Services Plan, this report endorses virtually all aspects of the plan and, with a small reduction, recommends funding for each strategy for which there is not yet an appropriation request or other funding source identified in the plan, with the exception of a proposed research project. These strategies include:

- Increased contracted mental health professional hours for
 - Screening upon intake of each inmate and, when indicated, referral, assessment, compilation and execution of a single, integrated, individualized treatment plan;
 - o Specialized treatment services for inmates who are self-injurious;

- Specialized treatment services for inmates with serious mental illnesses, and significant co-occurring substance abuse.
- Increased Department of Corrections staffing
 - 8 mental health service coordinators to oversee intake and discharge, ensuring systematic planning, transition, follow up procedures, management of treatment teams, etc. Also, screening identification and coordination of services for current incarcerated offenders in need of mental health and substance abuse services.
 - 9.5 mental health aides to support the prison security staff's facilitation of behavioral interventions, observations of inmates in crisis, and other assistance to inmates who need to adapt and function in the prison setting.

Timeline: SFY 2006, based on transition plan assumptions, below.

7. Agency of Human Services Initiatives

o Care management

The care management function would provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), interoperable or accessible information systems, ¹⁰ and both care management and utilization management oversight. Specifically, we envision creating a service network that coordinates the following components:

- General hospital psychiatric inpatient beds.
- Specialized psychiatric inpatient beds.
- Psychiatric ICU beds.
- Corrections mental health services.
- 18 existing mental health diversion / triage beds.
- 10 new diversion / triage beds.
- Existing and future public inebriate beds.
- Access to the new adult outpatient capacity, for community reintegration.
- Inpatient, residential and outpatient substance abuse treatment services.

¹⁰ The feasibility and cost of such a system is unknown at this time. There may be simple, low-cost ways to accomplish a satisfactory result on an interim basis, such as a practice of sending end-of-day electronic transmissions with bed counts to the on call site.

Key roles in the care management process include:

- Acute care screeners, 11 an existing 24/7 position in each of the 10 designated agencies, with responsibility for assessing level-of-care needs for individuals within a given region;
- <u>Clinical coordinator</u>, a new, on-call role with a statewide conflict resolution responsibility to ensure access to available, appropriate hospital or community-based services;
- Prison-based mental health coordinators, new positions that are responsible for coordination of mental health services, starting with intake, continuing through the period of incarceration, and arranging community services following transition to parole or furlough status;
- Department of Health clinical care management team, a new staff of 2.5 FTEs to monitor quality parameters and system issues, and to assure that systemic issues among partner organizations, such as bottlenecks, service refusals, inappropriate level-of-care assignments, are identified and improved.

For each type of program, a level of care protocol would be developed that indicates the specific responsibilities of each component of the network. Rigorous clinical criteria for admission and discharge from each program also would be developed, implemented and monitored. Programs performing the same function within the system, e.g. triage beds, would have the same admission and discharge criteria regardless of who the host organization is.

The acute care inpatient system would be accessed through an evaluation by a qualified mental health professional (QMHP) who, based on an assessment, would identify the most appropriate level of care. This clinician would have the authority, granted by the provider organizations and the Department of Health, to make a referral to the indicated level of care and, using a web-based tracking system, would be able to identify the nearest available service to meet the need. The admitting authority (for hospitals, a psychiatrist) would be expected to accept and treat the patient if the individual met the criteria for that level of care and no extenuating circumstances precluded it. ¹²

¹¹ In the current system, emergency screeners, also called QMHPs or qualified mental health professionals, perform the specific function of determining whether or not an individual meets the statutory criteria for involuntary care. The role of the screener in the transformed system shifts the emphasis to identifying the options for voluntary care. See The Vermont State Hospital Futures Plan for a full description.

¹² This would necessitate a change in the role of the QMHP from the more narrow screening and gate-keeping function to include a more robust assessment function in which the QMHP would recommend the level of care and program that is most appropriate to meet an individual's needs, based on the clinical presentation and the use of standardized instruments, trauma-informed best practices, availability of peer and staff resources, and the available resources in the person's personal network. Screening protocols for trauma and substance abuse in addition to mental illnesses would be universally implemented. This would

An on-call, designated hospital-based clinical coordinator, with a statewide system perspective, would be empowered to resolve any conflicts or disputes that might arise. In addition, improvements would be made to the transportation network (see below) to facilitate the safe transport of acutely ill clients between participating programs.

The Health Department clinical care management team would follow each client's course of care across program settings and department boundaries. Particular attention would be directed toward reintegration of patients from hospital treatment into the community setting. The team would facilitate the resolution of system issues and maintain utilization and quality management information for the entire network.

o Expansion of the co-occurring disorders project

This is a successful, ongoing, five-year collaboration between the Department of Corrections and the Department of Health divisions of Mental Health and of Alcohol and Drug Abuse Programs. Using integrated mental health and substance abuse treatment plans, teams in Burlington and Brattleboro provide outpatient treatment to severely ill and addicted offenders. These teams combine Corrections' field staff, mental health clinicians, and substance abuse clinicians. Clients are seen daily in the community or in group treatment. Results show a markedly reduced risk of re-offense, reduction in hospital care, and good recovery results. We propose to develop two new teams, in Rutland and Barre.

o Public health prevention and education strategies

With the reorganization of the Agency of Human Services, the divisions of Mental Health, of Alcohol and Drug Abuse Programs, and of Community Public Health are now together within the Department of Health. This creates a special opportunity to apply public health, population based prevention and early intervention techniques to the field of mental disease and substance abuse. New resources will be used to craft and communicate the public health, early intervention message with respect to mental illness. We will continue and expand on work presently being done with primary care physicians and their staffs on diagnosing and treating

necessitate the development of clear performance standards and an enhancement in the level of expertise, training and oversight of individuals in this key position.

depression, and on making referrals to appropriate specialized services. This work will benefit from coordination with Vermont's chronic care initiative, the Blueprint for Health.

8. Miscellaneous Services

Legal Services

The continuing decentralization of involuntary hospitalization has stretched the legal resources for both the state and patients to a point where adequate representation is at risk. Additional lawyers are needed for both the Attorney General's Office, which represents the Department of Health, and for the Mental Health Law Project of Vermont Legal Aid, which represents patients.

Transportation

The Department of Health is generally responsible for transporting individuals who are being or have been admitted to a hospital for involuntary inpatient treatment or evaluation. The Department contracts with county sheriffs, which raises a host of issues about trauma, privacy, coercion and restraint. To the extent that the sheriffs' service will continue to be a primary means of transport, this plan contemplates new training, protocols and standards for that service. It is also of interest to determine whether peer or other organizations, through an RFP process, could arrange transportation alternatives for those in voluntary treatment.

Transition Plan Issues

Notwithstanding decertification, until the IMD issue is dealt with, we won't have the federal contribution necessary to fund this plan. The fundamental transition issue is that a new facility slated for construction may not be available for occupancy for two to four years, depending upon site and other issues. In the near term, therefore, a proposed new facility won't relieve the IMD exclusion at VSH. Other strategies will be necessary in order to move this plan ahead.

1. Preferred Transition Plan: Global Commitment

If the Medicaid global commitment approach now under discussion is approved by the federal government, ¹³ our intent is to build the cost of this plan into the baseline calculation, yielding substantial federal cost sharing

¹³ Under the global commitment now being negotiated with the federal government, federal regulations regarding Vermont's Medicaid money would be relaxed to allow Vermont to find innovative ways to maximize the use of the funds.

going forward. The specific amount is subject to negotiation. The federal contribution would be available in SFY 2006 and could be spent flexibly, irrespective of the IMD status of VSH. Therefore, we anticipate that sufficient funds would be available to launch each element of the plan indicated for FY 2006.

2. Second Choice: Immediate distribution of most VSH services

If the global commitment approach is not available, the best option would be to take steps to shrink the VSH census as quickly as possible, shifting to arrangements that would qualify for federal Medicaid participation. This strategy would involve:

- Proceeding immediately with the sub-acute and secure residential plans, which would reduce VSH census by about 22 individuals.
- Engaging other hospitals, most likely currently designated hospitals with extra capacity, to take over the acute care of as many patients as appropriate.
- 3. <u>Least desirable</u>: Delay the whole plan until SFY 2009 or provide bridge funding.

In the event that neither the global commitment nor the distribution of VSH services is a workable solution, the remaining alternatives are:

- To postpone execution of this plan until a new facility is built and ready for occupancy, or
- To seek bridge funding from state general funds.

Designated Agency Sustainability

As called for in Sec. 141, a report was delivered on November 15, 2004, in the form of a letter from the Secretary of the Agency of Human Services to the co-chairs of the Mental Health Legislative Oversight Committee, addressing issues of financial sustainability of the community mental health designated agency system. The report cites the extraordinary importance and value of the community mental health system, and acknowledges the financial stress faced in the system. It recommends a fundamental change in the appropriations process whereby the executive and legislative branches, together with the designated agencies, would mutually commit that, for thee years, state funding for core service levels would increase 7.5 percent in each year, no more and no less. New services and projects would require new funding.

In addition, the November 15 report recommends that a significant portion of the annual 7.5 percent increase be directed to cost of living and inflationary increases for the designated agencies. From a service expansion standpoint, the report recommends that, in allocating the remainder of the annual increase, special consideration be given to adult out-patient, substance abuse and emergency services. These services are identified

because they offer opportunity for prevention and early intervention to avoid more severe illness. They are also areas where funding has been constrained. Last, the report calls for a structured process to move the system definitively in the direction of collecting consistent, relevant data and achieving a high level of system performance management.

The recommendations in the November 15 report have gained the endorsement of several organizations including the Council of Developmental and Mental Health Services, the Vermont Association of Mental Health, and the National Association for Mental Illness.

Relationship of the Designated Agencies to This Plan

This plan offers a number of new or expanded service opportunities to the designated mental health agencies. The opportunities would be paid with new funding, above and beyond the 7.5 percent increase for core service levels, and would be awarded based on RFP processes.

Under "Care Coordination," this plan also strengthens the designated agency role for emergency screening, authorization of the indicated level of care, and placing the individual in the closest appropriate setting. It supports that role with an information system that links all of the care partners and gives visibility to where there are appropriate vacant beds in the network.

Relationship of Designated Hospitals to This Plan

The designated hospitals play a critical role in the system of care and would continue to do so under this plan, with some expanded scope of responsibility. First, after an RFP process, the hospitals designated to participate in these services would agree to admit all persons referred who met certain clinical criteria that they would help to develop. ¹⁴ These criteria would be put in place for each type of program and level of care in the network, and would be managed consistently across all providers of the given type of program (see "Care Coordination").

Provision of Non-emergency Involuntary Psychiatric Medication

At present, VSH provides the only program in which non-emergency involuntary medication under the terms of Act 114 is provided. In the transformed system that is envisioned, the implementation of Act 114 would be extended to the designated hospitals. This would require a) developing new standards for designation; b) designating participating partners; c) training staff in the Act 114 regulations and required protocols, and d) creating rigorous oversight as part of a quality management system.

it is unable to provide.

¹⁴ Three of the four hospitals that responded to the RFI tentatively agreed to accept all appropriate admissions regardless of acuity, ability to pay, catchment area, etc., provided such designated units were adequately funded, staffed, architecturally configured, etc., to provide the service. This is sometimes referred to as having a "no reject" policy. No hospital would be asked or expected to provide a level of care

Conclusion

From adversity, Vermont is presented with a unique opportunity to transform the delivery of hospital-based mental health services, and to substantially strengthen the overall continuum of mental health and substance abuse services. While this plan was not designed as the response to Governor Douglas' directive to accelerate the process for reducing the VSH census and then closing the facility, many elements of this plan can be enacted promptly. By Tuesday, February 8, 2005, I will present an action plan that responds directly to the Governor's instruction. To the greatest extent possible, that action plan will dovetail with the vision presented in this report.